black hills
PSYCHOLOGY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____ _____
NAME OF CLIENT DATE OF BIRTH

I authorize Black Hills Psychology, LLC
115 N. 7th St., Suite 6, Spearfish, SD 57783 (fax: 605-717-1009) to:
____ obtain information from
____ disclose information to
____ exchange information with

Name:_____
Address: _____
Phone/Fax: _____

The information is needed for:
_____ Treatment Continuity ____Treatment Consultation _____At the request of the client
_____ Other _____

Dates of Services Requested:
_____Complete _____Present episode of care _____ Past 7 years of medical records

Check below the specific information to be disclosed:

( ) Social/Psychological/Psychiatric Assessment
( ) Progress Notes
( ) Diagnosis
( ) Dates of Treatment
( ) Treatment Plan
( ) School Records
( ) Other (Please specify):_____
( ) Psychological Testing
( ) Medication Evaluation/Follow Up
( ) Summary of Treatment Contacts
( ) Discharge Summary
( ) Chemical Dependency Tx/Eval
( ) Laboratory Reports

_____ This authorization shall remain in effect for one year of the date signed below.
_____ This authorization ends in less than one year. Date of expiration is _____

--I understand I may revoke this authorization, in writing, at any time by sending such written notification to the above office address. However, my revocation will not be effective to the extent that action has been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest claim.

--I understand that providers generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

--I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

--A photocopy is valid as the original bearing my signature.

_____ _____
Signature of Client Date

_____ _____ _____
(or Legal/Personal representative) (By what authority) (Date)